STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155546	A. BUILDING _____ B. WING _____	C 07/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL POINTE HEALTH AND REHAB	**3400 W COMMUNITY DR MUNCIE, IN 47304**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00132114. Complaint IN00132114 - Unsubstantiated due to lack of evidence Survey date: July 23, 2013 Facility number: 000565 Provider number: 155546 AIM number: 100267630 Surveyor: Betty Retherford RN Census bed type: SNF/NF: 68 SNF: 17 Total: 85 Census payor type: Medicare: 19 Medicaid: 53 Other: 13 Total: 85 Sample: 3 Bethel Ponte Health and Rehab was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint IN00132114. Quality Review 07/24/13 by Lisa McColly	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE